CRIBS FOR KIDS REFERRAL FORM

Once completed, this form can be saved and attached in an e-mail to Courtney.Rapone@state.de.us or printed and faxed to (**302) 577-1129**. If you make a referral by fax, please e-mail Courtney Rapone at the above address to confirm receipt. For questions or concerns please call **(302) 255-1743**. Your request will be processed within two business days. Thank you.

Referral Criteria: Check all that apply

☐ Baby is due within six weeks of referral
☐ Baby is less than twelve months of age
☐ Parents do not own an appropriate crib and are unable to purchase one
☐ Other, describe _____

Mother's Information

Name of mother/guardian: _____ Mother's DOB: _____
Mother's address: _____
Mother's e-mail: _____
Home phone: _____ Cell phone: _____
Other relevant maternal information (e.g. Spanish-speaking, substance abuse):
_____
Race (check all that apply): ☐ Asian ☐ Black ☐ White ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Is there smoking in the home? ☐ Yes ☐ No. If yes, check: ☐ Mother ☐Other:_____
Will baby be in daycare? ☐ Yes ☐ No
If Yes, check: ☐ relatives/friends ☐ center-based ☐ home-based
Mother's level of education: Last grade completed:_____ and currently in school? _____
Baby's name: _____ Baby's gender: ☐ Male ☐ Female
Baby's due date: _____ Baby's DOB: _____

Baby's Condition

☐ Full-term ☐ Healthy ☐ Health Issues ☐ Baby will be home on apnea monitor
☐ Premature ☐ Substance Exposed Infant ☐ Other _____

Mothers Health Insurance: ☐ Medicaid ☐ Private ☐ None

If Medicaid, please specify:

Baby's Health Insurance: ☐ Medicaid ☐ Private ☐ None

If Medicaid, please specify:

Referring Agency Information

Date of Referral: _____ Referring Agency: _____
Referring Contract Person: _____
Phone number: _____ E-mail: _____

Mother/Baby are currently involved with the following agencies (Check all that apply):

☐ DFS ☐ Home Visiting, specify which service_____
☐ DPH/Smart Start ☐ New Beginnings ☐ Other:_____

Updated 6/23/16